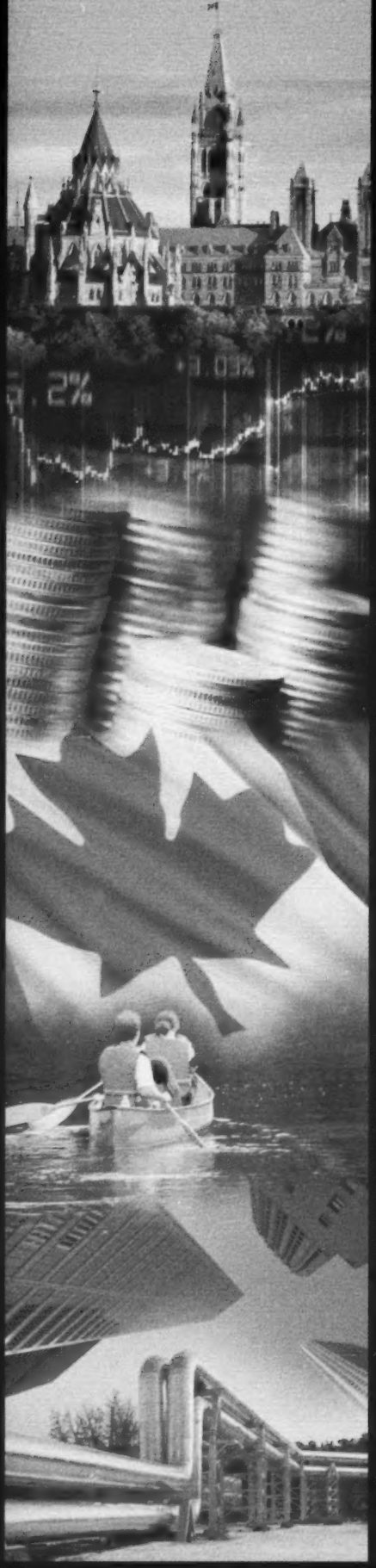

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COMMENTARY
NO. 415

Paying for the Boomers: Long-Term Care and Intergenerational Equity

As lifespans lengthen, more elderly Canadians will need long-term care (LTC). With the boomer generations retiring, there will already be great pressure on younger taxpayers, so now is not the time to ask government to take on a larger share of LTC costs. Private savings and insurance should be encouraged instead.

Åke Blomqvist and Colin Busby

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The Study In Brief

The aging of Canada's babyboomers is going to put significant pressure on the way in which we pay for and organize long-term care (LTC) services. The demand for LTC services remains relatively small for the first decade of life after age 65, but rises sharply around the time people turn 80. Looking closely at the demographic projections, once the first boomer cohort enters into the 80 and older group – roughly around 2030 – the demand for LTC will sharply increase.

Under current systems of delivering and paying for long-term care, we estimate that the cost of long-term care services will roughly triple over the next 40 years, growing from around $69 billion in 2014 to around $188 billion in 2050, in inflation-adjusted dollars. Public LTC costs are estimated to grow from around $24 billion in 2014 to around $71 billion in 2050, and the private burden is anticipated to be even higher, growing from around $44 billion to about $116 billion over the same period of time. Policymakers must therefore act soon to improve the way we finance long-term care.

The apparently simple solution of expanding Canada's public health system to cover all LTC costs should be rejected due to the additional stress that the expected growth in costs would put on future budgets and taxpayers of working age. The number of seniors relative to the working-age population is rapidly increasing and the economic growth rate appears to be falling, meaning today's working-age generations likely will not have incomes grow fast enough to offset the programs' rising public costs. Intergenerational equity concerns should factor into decisions to expand the public share of LTC costs.

A multi-pronged solution to better target means-tested public subsidies and allow growth of private insurance and savings should be pursued instead. Policymakers could do so in a manner that assures LTC access for those who need it but can't afford it. And because many Canadians today believe, somewhat falsely, that governments will pay for their future LTC costs, reforms must encourage individuals to take on a greater responsibility to pay for their own future LTC. It's important to strike the right balance between the costs to government or taxpayers and those that can be reasonably borne by individuals.

Provincial governments should proactively formulate a consistent set of means tests to determine what patients will have to pay and appropriate subsidies if and when they no longer have the means to do so. Clear and widely publicized rules of this kind would go a long way to help boost personal savings for LTC and increase the demand for insurance from individuals who want to secure their assets for future generations. Policymakers, meanwhile, face many urgent issues with respect to guaranteeing LTC access for those who cannot pay for it themselves, including waiting lists and the imbalance between institutional and home-based care, which should be another priority in the coming years.

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Cash-strapped provincial governments face a new challenge in the years ahead. Looming on the horizon are steeply increasing long-term care (LTC) costs, a function of Canada's aging population. Indeed, LTC will become a major component of future healthcare costs, which are generally projected to grow faster than the economy as a whole (Dodge and Dion 2011).

In the national debate over Canadian health policy, LTC tends to receive relatively little attention, partly because it is not included in the *Canada Health Act*'s rules against user charges that restrict how the provinces are allowed to finance physician and hospital services. If they need LTC, patients may have to pay substantial costs, and it is entirely up to the provinces to decide how LTC financing will be divided between government and private sources.

Some have held up LTC as an anomaly: since it is a form of healthcare that may be urgently needed, why is it not covered by our medicare system? Accordingly, it has been argued that Canadian healthcare coverage should include LTC, with small or no user fees. That is, the financial risk on individuals and families should be eliminated, and access to needed care guaranteed by having provincial governments pay for LTC as they do for hospital and physician services.

Those who advocate such reforms point out that among individuals who survive to an advanced age, over half will have a disability of some kind, and many will need nursing home care, some of them for a long time. Most elderly Canadians do not have enough resources, whether in accumulated savings or from private LTC insurance, to pay for LTC over an extended period. Indeed, many Canadians don't realize that LTC is not part of medicare and underestimate its possibly substantial cost under current provincial rules.

While we recognize that every province must have programs to ensure that those who urgently need LTC have access to it, we nevertheless argue that provinces should provide subsidies only to those individuals or families who otherwise would have difficulty accessing needed care, at least for the next decade or two. Those with the means to pay for LTC should bear the burden of paying most of these costs themselves. Extending universal public financing to all LTC services would mainly protect the ability of relatively well-off retirees to pass on assets to their children. It would also worsen what many already perceive as a lack of intergenerational equity in Canada's public finances.

Working-age taxpayers in Canada, as in many other countries, will face an increasingly heavy burden as they pay for many programs – including considerable LTC subsidies – that benefit the large cohorts of babyboomers who will retire in the next several decades. Younger taxpayers who were born

The authors would like to thank anonymous external reviewers and members of the C.D. Howe Institute's Health Policy Council for comments on earlier drafts of the paper. The recommendations and any errors in the paper are those of the authors.

after the babyboom (post-1965) are already being asked to contribute more toward the cost of their own retirement as employers shift to defined-contribution plans and as the Canada Pension Plan (CPP) becomes more funded. We don't think it is equitable to ask these relatively small cohorts of younger taxpayers to both save more for their own retirement needs and to pay a large share of LTC costs for boomers with sizable incomes and assets.

As an alternative to increased government funding, provinces should consider policies that would encourage boomers who still are working to save more toward paying a larger share of their LTC. To this end, provincial governments should formulate more explicit, clear rules on the future scope and form of government subsidies for LTC, creating awareness of the private costs that patients and their families may face. Such policies would also create a greater role for private insurance in LTC financing.

This *Commentary* draws on available data to quantify the expected cost of LTC in Canada along with the financial and other risks for elderly Canadians and their families under current systems of delivering and paying for LTC.[1] It shows how the projected aging of Canada's boomer bulge over the next several decades would raise the taxation burden on the working-age population under the status-quo LTC financing system.

Based on this scenario, we argue that there is a strong case for asking retiring babyboomers to pay for most of their LTC if they have the means to do so and limit government subsidies to those with low income or few assets. We also discuss how provincial governments could plan for a more balanced LTC-financing model in the post-babyboom era by learning from approaches in other countries. Finally, we consider longer-term options for mitigating the financial risk of LTC costs through policies that increase private or public risk pooling.

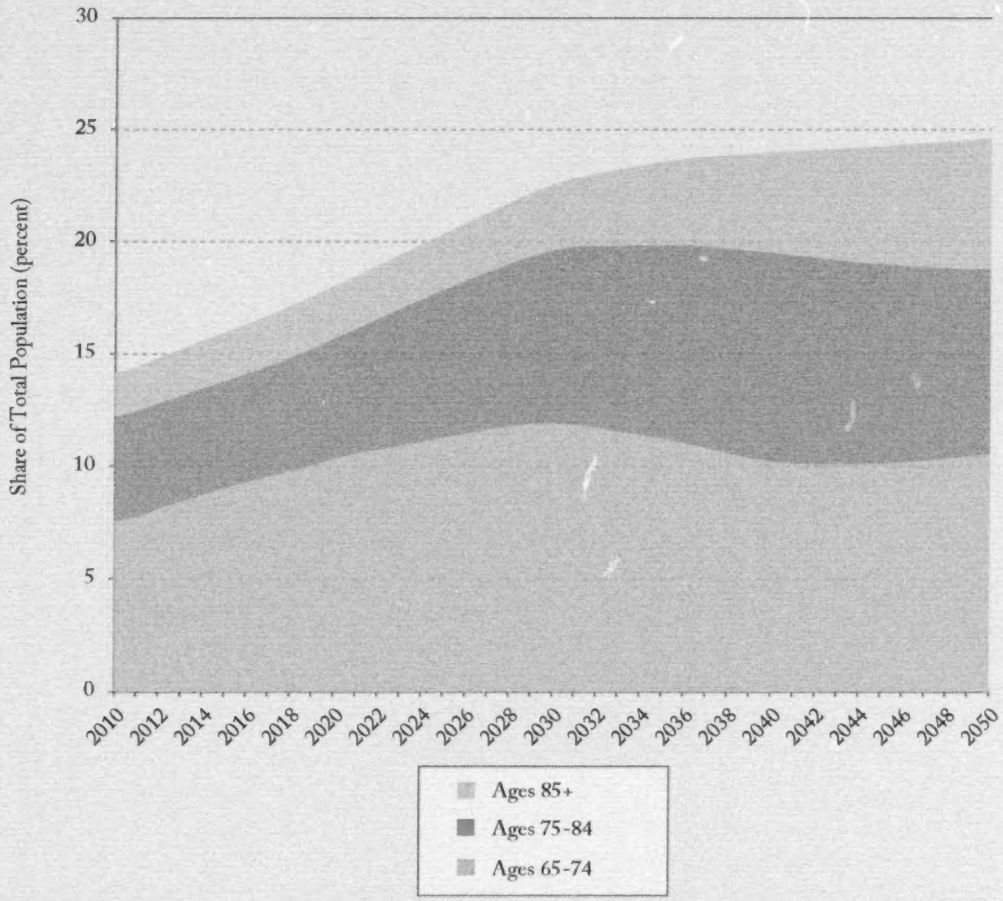
Population Aging and Future LTC Costs

Since seniors are those most likely to have health issues that require LTC, the aging of Canada's population will increase the number of individuals needing access to these types of care. According to Statistics Canada's medium growth demographic projections, the population's share of seniors will grow sharply, from approximately 16 percent in 2014 to around 23 percent in 2030 (Figure 1). It will continue increasing thereafter, but at a much slower rate, to about 25 percent of the total population in 2050.

Looking more closely at the demographics, however, we observe important shifts in the composition of Canada's senior population. As the babyboomer population heads into retirement, the share of so-called young seniors aged 65-74 will rise from roughly 9 percent to 12 percent of the total population by 2030. As the boomers continue to age, the number of elderly seniors – those aged 85 and up – will grow from around 3 percent in 2030 to 6 percent in 2060. Needless to say, these trends will contribute to an increased demand for both institutional and home-based LTC.

1 A reviewer notes that the LTC sector is undergoing a great deal of change, in particular with respect to the relative importance of institutional and home-based care, so an assumption that current patterns will continue is unrealistic. While we agree that patterns of care are likely to undergo change, our emphasis in this *Commentary* is on aggregate costs and financing, and their relation to population aging. It is not clear to us that changes in current LTC patterns will lead to lower (or higher) costs than in our scenarios.

Figure 1: Canada's Aging Seniors and Frail Elderly, By Age Group, 2010 to 2050

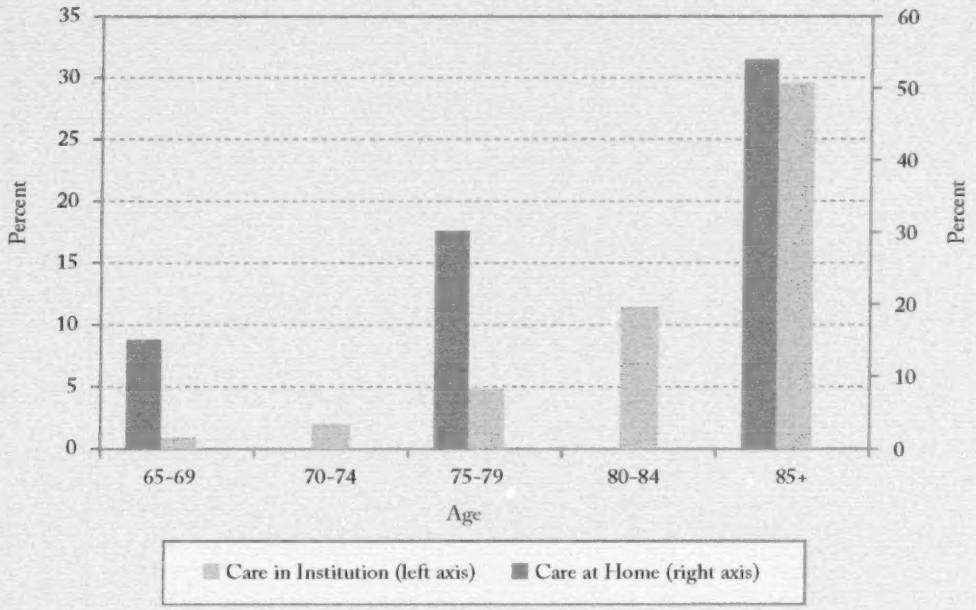


Source: Statistics Canada Population Projections.

To predict the impact of population aging on LTC costs, one must take into account the fact that the expected demand for LTC, on average, remains relatively limited during the first decade of life after 65 but rises sharply around the time people turn 80. Figure 2 shows that under 20 percent of seniors require any kind of LTC before age 75; by age 85, in contrast, disability rates grow and over half require either homecare or institutional LTC.[2] Institutionalization rates among young seniors

2 Canadian rates-of-care needs by age group are largely comparable to those recorded in the United States (CBO 2013).

Figure 2: Long-Term Care Needs, By Care Location and Age Group



Source: Statistics Canada (2013).

(those between 65 and 74) is low, and well over half of nursing home stays are by individuals older than 80.[3]

LTC: How Much Does it Cost Today?

While some LTC patients are younger disabled individuals, the majority are elderly people whose ability to perform the normal activities of daily living has been diminished by some type of physical or mental-health problem, or even just by old age.

Some elderly LTC patients get better and return to normal health and living, but most do not. The health problems they suffer from are typically chronic and irreversible, continuing until death. The care they need includes not only drugs and the services of trained health professionals, but also what is referred to as "personal care," such as bathing, dressing and other routine activities that can be performed by people without medical training, including relatives and friends as well as paid outside workers.

3 The institutionalization rate is currently only 7 percent of the entire population over 65 (Statistics Canada 2013). Most of the younger individuals (younger than 65) who receive institutional LTC are in facilities for persons with disabilities.

This *Commentary* examines what current demographic projections imply for future growth in demand and costs for LTC services provided in institutions or at home if current patterns of care were to remain unchanged. Although the patterns are likely to change, partly in response to an increased policy emphasis on home-based care rather than in institutions, our purpose is merely to show the need for more attention to LTC's aggregate costs, as the burden they will put on the public finances will grow dramatically unless serious efforts are made to rein it in.

Because there is no single authority that supplies statistical information on the kinds of long-term care provided for different age groups, we combine data from several sources for our estimates. With the help of a few straightforward assumptions, we develop estimates for the number of people who will receive i) formal care in institutions, ii) formal care at home and iii) informal care.

For the next step, we put together publicly available information to estimate the average per-person costs by care setting, with 2010 as the base year.[4] We estimate the annual average cost per recipient of institutional care to be roughly $60,200 per recipient in 2014 dollars, while formal homecare costs are $18,000 and informal care about $21,900. The rationales behind our choices are explained in greater detail in Appendix A.

Projecting Future LTC Costs

Because the number of patients receiving institutional LTC is a relatively small proportion of "young seniors" below age 75, the burden that this form of care will impose on society over the next 15-20 years is manageable, even though the senior population will grow rapidly as babyboomers retire. However, when the boomer cohorts reach ages 80 and older (many of whom will be the "frail elderly"), LTC costs will grow very rapidly.

Combining population forecasts with age-specific utilization rates and the cost estimates for different types of care, we project total annual LTC care costs to roughly triple over the next 40 years, growing from around $69 billion in 2014 to around $188 billion in 2050 (Figure 3). At current utilization rates, institutional care and informal care would form the bulk of future LTC costs.[5]

Not surprisingly, the most rapid increase in costs occurs between 2025 and 2040, when the babyboomers are expected to dramatically expand the numbers of frail elderly. Thus, policymakers have a window of about a decade to design policies that will soften the impact on future hard-pressed taxpayers. Many babyboomers will still have time to adjust their savings and insurance plans to properly take account of not only the need for retirement income but the possibility of high LTC costs as well.

LTC Costs: Who Will Pay?

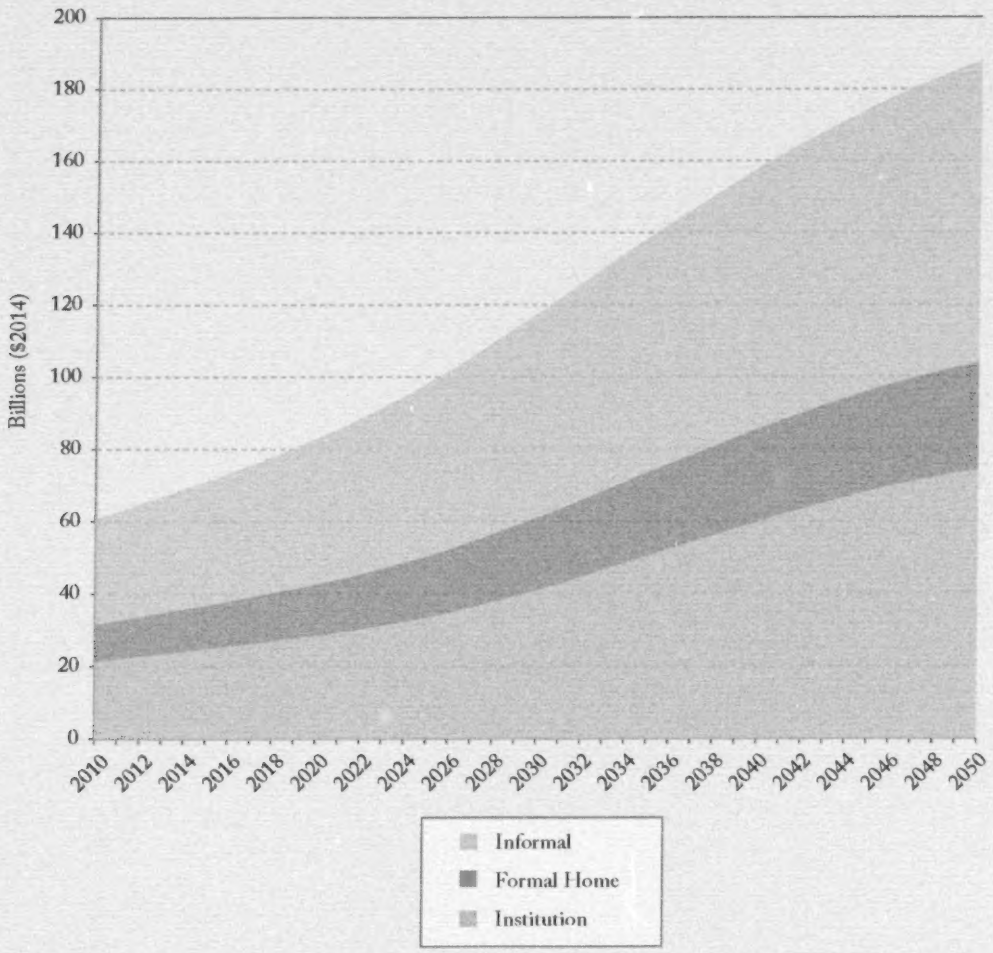
In today's system, LTC costs are split between provincial government and private sources. While provincial governments finance about three-quarters of institutional LTC costs, individuals also pay considerable charges, either out of pocket or through supplementary private insurance.[6]

4 See Appendix A for a detailed explanation of how we derived these estimates.

5 Since LTC is undergoing substantial changes, toward a pattern where more and more of it is supplied in patients' homes while institutional care is reserved for those with the most severe degrees of disability, it is obviously not realistic to assume that utilization rates will remain constant, as noted earlier. However, even if future LTC patterns will look different from today's, we expect our projections of their aggregate cost will be close to the mark.

6 The private share of LTC costs in BC and the Atlantic provinces is generally higher than the national average (Blomqvist and Busby 2012).

Figure 3: LTC Costs Projections ($2014), By Location of Care, 2010 to 2050



Source: Authors' calculations as described in text.

Many provinces aim to set patient fees for institutional care according to the "hotel" costs of room and board, while paying for most health-related costs, such as nursing or physicians services. For subsidized homecare, the province pays an even smaller share of the total costs, and in most cases those services have to be supplemented by family-member informal support.

For the large numbers of elderly people whose only source of LTC is informal care, the entire cost

is borne by the caregivers.[7] Informal care costs are often not part of the policy debate, even though they may be heavy, with elderly spouses carrying much of the burden and adult children having to take time off work to care for elderly parents.

If the government's share of the cost of different types of LTC were to remain constant, public LTC costs would grow from around $24 billion in 2014 to around $71 billion in 2050, in 2014 dollars (Figure 4). In the aggregate, our estimates show a private burden that is even higher, growing from about $44 billion in 2014 to about $116 billion in 2050. Looked at another way, the public cost of LTC would rise from $690 per person in 2014 to about $1,470 in 2050; annual private per-capita LTC costs would rise from $1,240 to $2,390 over that same time period.

The above projections are based on past financing of long-term care; i.e., it assumes that governments would fund future LTC services in ways similar to how they have done so in prior decades. As stated at the outset of this paper, the key question we want to address is whether policy should shift to provincial governments taking on a larger share of the cost, consistent with *Canada Health Act* principles that guarantee access to needed health services and protect individuals against the financial burden of paying for care. Our projections give an idea how costly such a policy would be, given the aging of the population.[8]

Moreover, in assessing proposals for increasing the government's share of the cost, one must keep in mind that the same demographic changes that will lead to a dramatic increase in LTC costs also imply an increased burden on the working-age population that pays most taxes required to finance not only LTC but all healthcare in general, as well as other programs that transfer income to the elderly.

Projected LTC Costs Relative to Income Growth

If we make the assumption that the Canadian economy will generate a constant per worker productivity growth rate, we can use our demographic forecasts to project a growth path for GDP. Using a historically observed rate of productivity growth as in Busby and Robson (2013), of 1.2 percent annually,[9] we can map our demographic projections to project future economic growth and compare it with the growth of LTC demand. In doing so, we estimate that LTC costs, including privately borne costs, will rise from approximately 3.5 percent of GDP today to a high of around 5.2 percent in 2040 (Figure 5). If government shares of different kinds of LTC costs remain constant, public LTC costs are projected to rise from 1.3 percent of the economy today to around 2.0 percent in 2040.

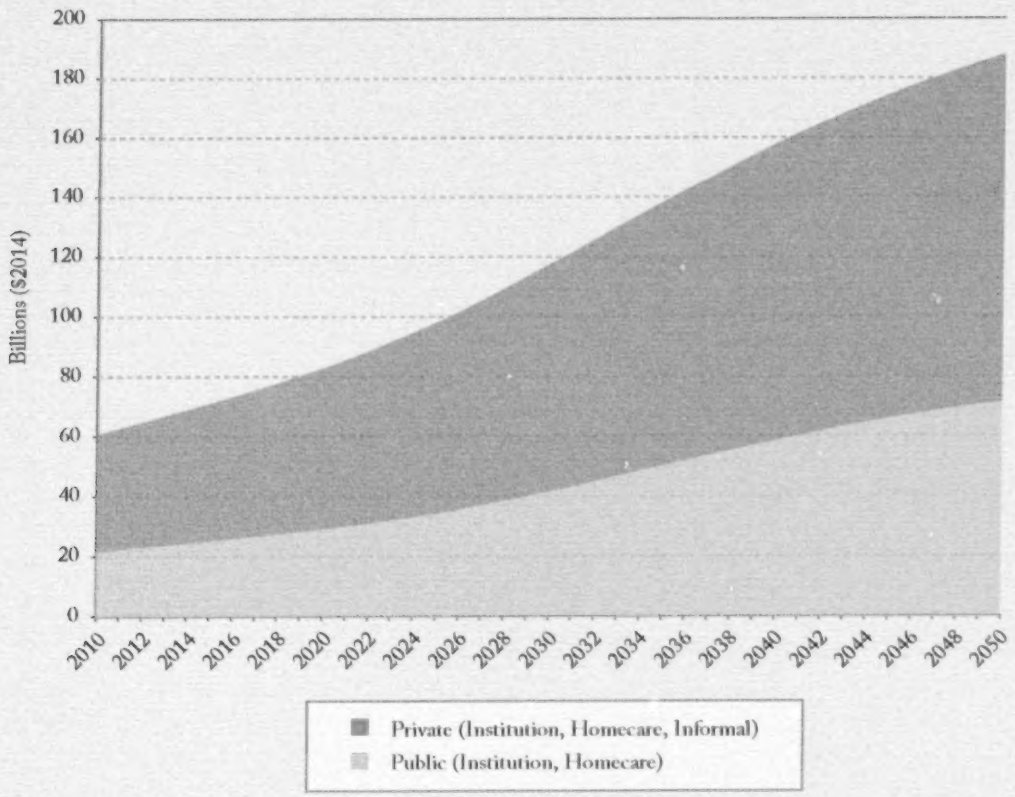
Such a 0.7 percentage-point (more than 50 percent) increase in the government's LTC costs implies that taxes must rise by an equivalent amount, as a share of total income, to help pay for Canada's rising LTC costs, even assuming status quo policies. This increase in the tax burden would

7 There are nominal supports offered to informal caregivers at both the federal level – via the Employment Insurance program – as well as at the provincial level where a few provinces provide small tax credits to caregivers. Given the nominal size and use of these programs, we did not include them in our cost projections.

8 Several reviewers noted that governments would likely not even have the fiscal capacity to support the projected increase in their LTC costs if their share of total costs were to remain unchanged. While our analysis focuses on how the costs should be shared, reviewers noted that governments can also seek to control their costs by pursuing policies that make LTC less costly in the aggregate, for example, by substituting less expensive homecare for institutional care, or by following more restrictive rules regarding access. We think these are important possibilities to consider in the policy debate, but we do not believe there are any easy options to reduce the total cost of projected future LTC needs.

9 For more information on the methodology, see Busby and Robson (2013).

Figure 4: LTC Costs Projections ($2014), Public and Private Sources, 2010 to 2050



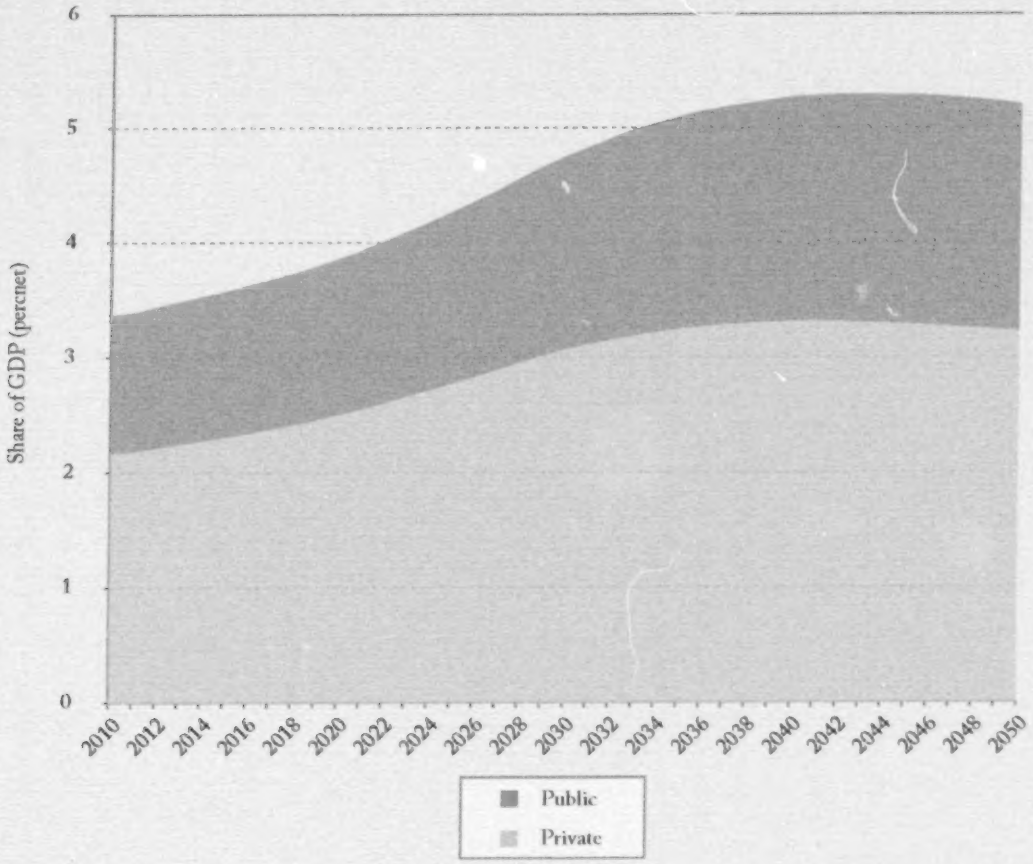
Source: Authors' calculations as described in text.

have to be borne mostly by generations of taxpayers with many more elderly dependents to support than is the case today.

If bringing LTC under the principles of the *Canada Health Act* means that the public system should take over the share of formal LTC costs that are currently privately funded,[10] this would add another 0.9 percentage point to the public share, to around 2.9 percent of GDP in 2040, more than double of what it is today. Moreover, this would

10 That is, the private shares of institutional LTC and formal homecare services, with the implicit costs of unpaid informal care continuing to be borne by the caregivers.

Figure 5: LTC Costs Projections as a Percentage of the Economy, Public and Private Sources, 2010 to 2050



Source: Authors' calculations as described in text.

come on top of the likely increase in the share of GDP that would have to be devoted to the kinds of health services that already are covered under medicare (all physician and hospital services) and the provincial governments' share of drug costs.

Public Finances, Demographic Change and Intergenerational Equity

Since LTC is largely used by older individuals, while most taxes are paid by those of working age, having provincial governments assume an increased share of LTC costs can be seen as an incremental

redistribution of income from those of working age to retired individuals receiving such care. But Canada already has a range of tax-financed, pay-as-you-go programs that, implicitly, redistribute income from younger generations to the old – notably Old Age Security (OAS) and Guaranteed Income Supplement at the federal level and acute healthcare at the provincial level (PBO 2012).

As we see it, the fact that increasing government's share of LTC costs would contribute further to what many already perceive as a high degree of intergenerational inequity should be given significant weight in considering this policy option.[11] The intergenerational equity issue today arises, in part, from the unusually high fertility rates from roughly 1947 to 1965, the years when the babyboomers were born. It is the high fertility rates from those years – and their subsequent decline to lower levels in the following years – that will produce the large and rapid increase in the share of seniors in Canada's population as the babyboomers reach retirement age through 2030.

Being part of a relatively numerous generation is, to some extent, an advantage in itself. Some government expenditures are essentially fixed costs (the costs of administering the federal and provincial governments, the foreign service, national defence…) and their burden can be spread over a large number of taxpayers, reducing the average payment per individual. Moreover, when the boomers were in the workforce, from which most tax revenue is derived, the number of young or old dependents (those younger than 15 or older than 65) was small relative to the total population. This reduced the average burden of the existing programs that transferred income or resources in kind to dependents – such as education or means-tested old-age pensions – that already existed at the time when the first boomers reached working age in the early 1960s.

Intergenerational Transfer Programs

As members of large cohorts, boomers have benefited from a relatively low tax burden while they were of working age. As they entered the workforce during the 1960s and 1970s, the Canadian economy grew rapidly in real terms, because the labour force and labour productivity were increasing at high rates. With rising prosperity, Canadians were willing to initiate ambitious social programs that would benefit population groups in need, including the elderly among whom the incidence of poverty continued to be high and those in ill health who sometimes could not afford even urgently needed care or whose families were impoverished by costly healthcare. These programs are contributing to today's growing intergenerational inequity issues.

Chief among them was the universal, tax-financed OAS plan which replaced means-tested old age pensions, raising the income of all retirees, many of whom also received benefits under the new Canada Pension Plan (CPP). Universal health insurance also originated during this period, with all provinces ultimately agreeing to establish tax-financed plans in return for a federal contribution to the cost.

OAS and provincial health insurance were both tax-financed, implying some degree of wealth transfer from younger to older generations, directly in the case of OAS and indirectly through provincial health insurance since people over 65 on average use more health services. CPP, in contrast,

11 A recent discussion of intergenerational equity in US social policy uses the term "fiscal child abuse" to characterize their current system (Kotlikoff and Burns 2012, p. 4). Much of the discussion in this highly readable book applies to Canada as well.

is financed through contributions from those of working age. However, in order to quickly address the problem of inadequate post-retirement incomes, it was designed as a partially unfunded pay-as-you-go plan under which benefits were paid from current contributions from those of working age. Even retirees who contributed to the plan for only a short time were eligible for benefits.[12]

The dramatic reduction in poverty rates among seniors that followed the creation of these programs (Osberg 2001) and the fact that seniors, as well as all Canadians, have guaranteed access to healthcare have rightly been considered major social policy achievements. But while the cost borne by working-age generations in financing these programs was less of a concern when the population's share of retirees was relatively small and average real incomes were growing rapidly, the situation today is different.

As already noted, the number of seniors relative to the working-age population is rapidly increasing and the economic growth rate appears to be falling, meaning today's working-age generations likely will not have incomes grow fast enough to offset the programs' rising public costs.[13] For public finances, this makes the timing of major changes to government spending programs important. Other countries have recognized this when planning LTC financing, even though most jurisdictions that cover a large share of LTC costs are also coming under great budgetary pressure to revise their LTC financing systems (Box 1).

Taken together, these factors create a strong case against new expenditure undertakings that will further redistribute incomes to retirees at the expense of working-age taxpayers over the next several decades. For this reason, we feel strongly that, rather than increasing the degree of government funding for LTC, serious consideration should be given to limiting LTC subsidies to lighten the burden on future taxpayers as boomers age.

Reforming Government's Role in LTC Financing in Canada

Proposals to limit or curb the governments' share of LTC funding are likely to be controversial, as they will increase the private costs paid by elderly boomers for their LTC. To have a chance to succeed, such reforms must be designed in a way that is consistent with the core values of Canadian social policy.

In considering alternative LTC financing measures, one needs to recognize that the current universal single-payer medicare system in Canada responds to two somewhat different societal objectives – guaranteed access to care for everyone who needs it, and an efficient risk pooling system.

The first of these is a fundamental requirement for a compassionate social policy. The second objective, in contrast, stems from the perception that a universal government plan will provide more effective risk pooling than private insurance. This perception may or may not be correct. However, our view is that as long as the guaranteed access objective is met, the choice between private or public coverage of what we refer to below as "residual risk" should largely be a technical one.

12 When CPP was created, the contribution rate was set at a low level, but since both the working age population and average incomes were growing rapidly, the total contributions were large enough to cover the defined benefits for the relatively small number of retirees at the time.

13 An additional consideration is that medical technology has advanced dramatically, meaning that the implicit promise that government plans will pay for seniors' healthcare is a much costlier one today than it was when medicare was created in the 1976s.

Box 1: LTC Financing Reform: Timing Is Everything

The intergenerational issues caused mainly by the large cohorts of post-war babyboomers have impacted the timing and design of age-sensitive public programs in other Western countries. The general trend of public program expansion in Western countries took place as boomers entered the workforce – a time in which workforce growth contributed to large increases in the income-tax base, making old-age-sensitive program spending, like healthcare, seem relatively affordable.

Holland introduced public LTC insurance in 1968, financed by income-based contributions; and Germany created mandatory social LTC insurance in 1995, financed out of general revenues and taxes (Costa-Font and Courbage 2011). While the cost pressures of both of these LTC insurance plans are stressing government budgets in Holland and Germany today, the fact that their systems to finance long-term care were put in place some time ago means that today's boomer population has been contributing to them for some time, whether through payroll contributions or taxes that have gone to finance the LTC costs of the generations of seniors who have received subsidized care since the programs started.

While the cost that today's seniors in these countries now are asking future taxpayers to bear is larger because the boomer generations are relatively large there too, at least they can claim that the extent of the intergenerational inequity is lessened because they have paid into the programs in the past. Canada's boomer generation cannot make this claim, and the extent of intergenerational inequity from introducing a large public LTC insurance program today would be aggravated both by the fact that the retiring generations who would benefit are relatively large, and projected to live much longer – hence require more LTC support – than the generations before them.

Once access to care for those who urgently need it is guaranteed, the question of pooling the residual financial risk has little or nothing to do with fundamental values of social justice. This is especially true in the case of LTC where, we argue, large-scale public pooling of financial risk would serve mainly to protect the assets of relatively well-off retirees.

Guaranteeing Access

Frail elderly and ill or disabled individuals must have access to LTC when they need it, even if they don't have the means to pay for it. It is no surprise, therefore, that all high-income countries have arrangements to guarantee access at public expense in such cases. Even in the US, where the government's share of healthcare costs is lower than in any other advanced country, a large portion of LTC costs are paid for by state Medicaid plans that also cover most routine healthcare costs of social assistance recipients and others who meet low-income criteria.

Canadian provinces currently guarantee access to LTC services according to an individual's need, but the amount of public support is often adjusted based upon one's means. All provinces have established public subsidies for nursing home care as well as homecare, though immediate access to either form of care is often based on the availability of services as well as the severity of individual needs. Private co-payments for either institutional or homecare are often adjusted according to one's ability to pay.

Our main conclusion is that means-tested subsidies to preserve this access guarantee should continue to be the guiding principle of provincial policy toward LTC financing. Efforts to make the access guarantee more effective, for example, by reducing waiting lists for institutional care or increasing the availability of subsidized homecare for those who need it but do not have the resources to pay for it, should also be policy priorities. In contrast, we oppose proposals to extend public coverage of LTC to those who can afford it. In our view, these proposals conflict with the generational equity objective.

Pooling Financial Risk

Means-tested subsidies to guarantee access to care for everyone can be considered a limited form of risk pooling – the cost of ensuring that nobody goes without urgently needed care, because he or she does not have the means to pay for it, is shared among all taxpayers. An additional justification for government support of universal healthcare is that it reduces the financial burden of treating ill health, even for those who can afford to pay for needed care on their own, or when illness reduces someone's income-earning ability.

In Canada, governments have completely shifted the financial burden of paying for care in hospitals or for physician services from patients to the community at large (taxpayers). By doing so, there is also pooling of the residual financial risk. In addition to ensuring access to needed care, government funding also converts the risk of devastating financial consequences from a major illness for a small number of individuals into a manageable burden for everyone.

But while some form of government intervention clearly is needed to guarantee access to health services, even for those who cannot afford to pay, the pooling of residual financial risk can be accomplished outside of government intervention through private insurance, either voluntary or mandated. Private insurance remains the main vehicle through which the financial risks associated with events like fires or automobile accidents are managed. It also continues to play a major role in reducing the burden of high costs for pharmaceuticals for a significant portion of the Canadian population.[14] The same is true for income protection in the event of disability. While governments and related agencies, such as workplace insurance boards, provide a minimum level of protection in the event individuals lose the ability to earn an income through illness or injury, private long-term group and individual disability insurance also provide some income protection in Canada.

Risk pooling through voluntary private health insurance is subject to well-known problems.[15] However, in an environment where government budgets are tight, policy must be selective. The possible advantages of expanding government pooling of residual financial risk into a new area where the beneficiaries will mostly be elderly retirees must be weighed against the

14 Even when private insurance is mandatory (as in the case of auto insurance), it is different from risk pooling through government funding in that it doesn't require additional tax revenue. Moreover, with private insurance, consumers typically have a choice among plans with different degrees of coverage and different premium levels, in contrast to a single tax-financed government plan.

15 These include high administrative costs, as well as equity and efficiency issues that arise as a result of risk selection by insurers and the tendency of individuals who know themselves to be at high risk to seek out generous insurance plans, thereby "spoiling the market" for those at low or average risks. These problems have been extensively studied in the context of comparing the US and Canadian healthcare systems. For a summary, see, for example, Hurley (2010), Chapters 10 and 11.

intergenerational equity issue and the difficulty of raising large additional revenues. Moreover, there may be areas where private insurance's financial risk-pooling function for those who can afford it can be encouraged through regulatory policies, even if government takes responsibility for guaranteeing LTC access for those who cannot.

LTC Costs and Financial Risk

The data presented earlier on expected LTC costs consider the average over all individuals. However, this burden is not evenly distributed. Only a minority will ever receive LTC in an institution, and many will die after only a relatively short period of illness. But for the minority who do need LTC for a long time, whether in an institution or at home, the financial burden can be very large.

Studies from other countries suggest that the length of stay in institutional LTC care may be as long as two to four years, and Canadian informal caregiving data include a significant proportion of cases where it has been provided for more than four years. For long institutional stays, which are increasingly associated with a diagnosis of Alzheimer's disease, the costs can easily be high enough to deplete the entire wealth of even reasonably well-off individuals and their families.

The uneven distribution of costs associated with LTC implies that it has one of the characteristics associated with large potential gains from risk pooling – that a small share of the population will incur costs that are much larger than the average. At the same time, however, one can argue that the need for protection against these financial risks is not as great as for most other forms of healthcare. After all, most elderly people who receive LTC will not recover full health, but will continue to be LTC patients until they die. The benefit of risk pooling that protects their assets, therefore, will mostly accrue not to themselves, but to their heirs.

Although it clearly should be an objective of government policy to guarantee LTC access for those who need it and cannot afford it, the case for extending the government's role to residual financial-risk pooling for the purpose of protecting the assets of heirs does not seem as compelling. Instead, governments might encourage more effective financial-risk pooling through policies that enable private LTC insurance to play a more prominent role than it currently does, or through a social insurance scheme that is less costly than a commitment to pay for all LTC costs. We discuss these options in more detail below.

Better Targeting Government LTC Subsidies: Setting Means-test Rules

Reforming provincial LTC financing systems toward more emphasis on limiting government costs while preserving an implicit access guarantee means that new rules must be formulated for obtaining payment from those who can otherwise afford subsidized LTC services.

Such reforms, however, should proceed in parallel with continued efforts to overcome another problem that plagues LTC in several provinces. LTC access must be timely, not just guaranteed in a legal sense. Across Canada, access to LTC services often suffers from serious delays, resulting in long hospital waits, backed-up emergency rooms and a strain on family resources to provide homecare supports (see Box 2 for a discussion about LTC hospital waits and what to do about them).

In designing more targeted public subsidies for LTC, the two main issues faced by policymakers are the charges and means-testing rules that determine the amount of the public subsidy. That is, in subsidized nursing homes where patients who can afford to do so are required to defray part of the cost, there must be clear rules regarding:

- the maximum charges payable by those with resources above some threshold values for income and/or assets;
- what charges, if any, would be payable by those with the lowest income and/or assets;
- how charges for those with income or assets

Box 2: Alternate-Level-of-Care in Hospitals: The Access Guarantee and Waiting Lists

In spite of access guarantees for LTC, in several provinces there are lengthy waiting lists, especially for those who need institutional care. As always, waiting lists can be costly. In the LTC case, part of the cost is born by provincial health insurance plans and hence taxpayers: Many of those on waiting lists for LTC are patients who remain in acute-care hospital beds even though they have recovered sufficiently so that they could be cared for in a nursing home. Estimates have put the number of acute-care hospital beds that are occupied by such "Alternate Level of Care" patients at 1.7 million ALC bed days in 2007/08, with the largest share waiting for placement in a LTC facility or for appropriate homecare supports (Walker 2011; CMA 2013b).

Although it is not obvious how one could accurately estimate the cost to the community of this inefficient pattern of care, it is clear that it could be quite high. In particular, it contributes to the bed shortages that lead to overcrowded emergency department in many acute-care hospitals, or to the long waiting lists for certain types of surgery. Waiting lists for LTC beds obviously may also lead to hardship for patients who have become disabled and need care but who continue living at home because there is no bed available for them in a subsidized nursing home.

Because these explicit and implicit costs of waiting lists for LTC can be so high, we believe that measures to eliminate them should be a key policy goal in the provinces where they exist. The licensed nursing homes for which there are waiting lists are subsidized institutions that receive funding at rates negotiated with provincial governments and in which the charges paid by patients are also set by governments. In addition to subsidized nursing homes, the LTC industry also includes various private facilities in which patients pay the full cost of their care, at rates that are established in the market with little or no government regulation. One way in which governments could reduce the extent of the waiting list problem would be through expanding the range of institutions in which eligible patients could receive subsidized care.

That is, instead of subsidizing eligible patients indirectly, by requiring them to pay a charge below the cost to the government of the care they would receive in a subsidized institution, governments could offer them an explicit subsidy as an alternative – such as a voucher. This would allow an existing, or potential, ALC patient to use that subsidy toward paying for their care in an otherwise unsubsidized facility. Again, such an approach could be expected to reduce waiting lists in the subsidized institutions, as some patients would opt for care elsewhere even if it were to cost them somewhat more out of pocket, or if unsubsidized facilities were able to control costs and offer equivalent care at a lower cost than the subsidized institutions.

between these limits would increase with higher income or assets; and

- how the charges would depend on other factors, such as whether the patient has a spouse living in the community.

We discuss each of these items below.

Limiting Subsidy Levels

There are currently large interprovincial differences in the amounts that patients are required to pay when receiving subsidized LTC in either the community or in subsidized nursing homes. Nevertheless, the amounts that even those with high incomes are required to pay fall far short of the full cost everywhere (Blomqvist and Busby 2012).

For elderly patients receiving institutional care, the full cost includes the services of medical personnel (physicians and nurses) and drugs, both of which would be publicly funded, regardless of whether or not the patient was in an institution. However, to a large extent, LTC also consists of what would normally be classified as hotel costs – the cost of room and board – that would otherwise have to be paid by the person if living in the community. In addition, LTC patients typically receive various forms of personal care (help with activities of daily living such as dressing, bathing, feeding) that can be performed by persons with limited medical training (personal care workers) and therefore may not be classified in the category of medical professionals.

Many provinces claim that their private fees are set to cover only hotel and lodging costs. But based on the large variation in the private charges from one province to another – ranging from a low of $12,000 per year in Quebec to $36,000 in BC – this principle does not seem to be consistently applied. Greater clarity is required on this score.

Aggregate Canadian data suggest that the average annual cost of residential care is well over $50,000; in some studies it is estimated at well over twice that amount in many facilities (Hollander 2002). In the provinces that impose the highest patient charges on well-off patients (BC and Nova Scotia), monthly charges were only a little over $3,000 in 2011, or about $36,000 per year. In Ontario and Alberta, the monthly charges were about $1,400, or about $17,000 annually. One obvious way in which LTC costs could be limited would be to raise these charges to a figure closer to the full cost for those with a high ability to pay.[16] Based on the differences in private-facility care charges across the country, some provinces have more room to manoeuvre than others.

Revising Means Tests

The principle that everyone who needs LTC should have access to it, but only those who cannot pay for it themselves should be subsidized, requires some form of means testing. Means-testing procedures for institutional care already exist in all provinces. Some provinces also levy charges for certain types of homecare based on the recipient's income.[17] For single patients in nursing homes, the lowest regular charge is payable by those whose total income consists only of the maximum entitlements under

16 An obvious objection to this proposal is that it is inconsistent with the principle of zero user fees for medical care that many consider a cornerstone of Canada's provincial health insurance plans. The principle that patients should not be required to pay any part of the cost of their essential medical care is, of course, a key element of the *Canada Health Act*. The Act, however, technically applies only to services received in acute-care hospitals or from licensed physicians. At most, this may imply that the provinces would not be allowed to charge LTC patients for services they received from licensed physicians, but they would not prevented from requiring well-off patients to pay other costs, such as those attributable to nursing services, in addition to what can be interpreted as regular charges for room and board.

17 The Territories are unique in that they offer a universal subsidy without a means test for institution-based care.

the OAS and guaranteed income supplement (GIS) programs. When income is above that amount, the patient charge payable in most provinces increases dollar for dollar with additional income (that is, the subsidy is "clawed back") until income reaches the level at which the maximum charge applies.[18] Those with incomes below that amount essentially agree to transfer their full OAS and GIS entitlements to the provinces who then subsidize the rest of their LTC costs.

From the provincial government viewpoint, a high claw-back rate (or implicit marginal tax rate) will reduce the aggregate subsidy cost. The conventional argument against a high implicit marginal tax rate in social programs is based on the idea that it reduces the incentive for benefit recipients to increase their income by, for example, finding a job. In the case of LTC subsidies, this incentive effect is attenuated by the fact that most of the recipients' income will come from pensions or the return on assets that they accumulated during their working lives. Accordingly, the trade-off between incentives and the cost to the provincial government is different for LTC subsidies than, for example, for income-support programs for working-age people. For this reason, we think that the impact on the subsidy cost to the government should be the primary consideration in designing means-testing rules for LTC.

Including Assets

Means testing based on estimated annual income has the advantage of administrative simplicity since it can be based on tax returns. However, even though the purpose of means testing is to estimate a reasonable patient charge, a comprehensive definition of ability to pay should, in our view, also take into account seniors' assets, not just estimated annual income. For an elderly person with a relatively short life expectancy, the amounts he or she can afford to spend each year will depend more on the assets they own than on the current income they produce. While seniors with children or grandchildren may want to preserve their assets in order to pass them on, we don't believe this should be a consideration in assessing the degree to which taxpayers should subsidize their LTC.[19]

Currently, LTC charges are based only on current income in all provinces except Quebec and Newfoundland and Labrador where assets are somewhat taken into account. Other provinces should consider incorporating asset holdings in their means-testing procedures. This could be done in ways that would protect surviving spouses and not force seniors to sell assets prematurely. For example, collection of some charges could be postponed until after the patient's death, or the death of a surviving spouse. Collection of deferred

18 For LTC patients with incomes within this range, the reduction of the subsidy as income rises (the benefit clawback) effectively acts as an implicit marginal tax rate of 100 percent, along the same lines as were commonly observed in social assistance programs in the past. In two provinces, Saskatchewan and BC, the subsidy reductions in certain ranges are less than one dollar for each dollar of additional income, reducing the implicit marginal tax rate below 100 percent (in Saskatchewan, it is as low as 50 percent). All provinces also specify somewhat different rules when the patient is married with a spouse living in the community. The detailed rules are complex, but generally reflect the idea that the extent of the subsidy should be based on the couple's joint ability to pay, rather than on the way its joint income is derived. However, in several provinces, the charge that patients must pay is calculated on the basis of half the couple's combined income, meaning that the implicit marginal tax rate on the couple's joint income in the relevant range is only 50 percent, rather than the 100 percent that applies for single patients.

19 A reviewer has pointed out that including income but not assets in means testing creates an artificial incentive for elderly people to invest in assets that yield capital gains, rather than current income.

LTC service costs could be done in conjunction with the procedures for probating wills.

Meanwhile, a large number of Canadians have a great share of their personal wealth in their homes. Leveraging these funds to help pay for living expenses after retirement is an important example of how innovations in financing vehicles can help provide financial security.[20] Home equity should also be included in determining the public subsidy entitlement for an LTC recipient.

Increasing the Role of Private LTC Financing

Private LTC Insurance

Although the characteristics of LTC – a relatively low chance event with potentially high costs – make it an attractive insurance vehicle, only a tiny private LTC insurance market among seniors has developed in Canada. While a number of working Canadians have LTC insurance with their group employer plans, many of these plans do not cover post-retirement LTC costs, and only a small share of the senior population have private LTC insurance. There are several reasons why this market remains small.

One reason may be the widespread belief that governments will cover individual LTC costs, just as it covers other healthcare expenses. Surveys show that roughly 75 percent of Canadians have no plans to cover potential LTC costs, and 55 percent believe that government will cover at least half of their future LTC costs (CHLIA 2013).[21]

Clearly, many Canadians appear to be misinformed about the scope of public LTC coverage. Making people more aware of current rules and about the substantial LTC financial risks might increase the demand for private insurance, at least to some extent. Stricter means testing for LTC subsidies would make it even more desirable that people are aware of existing rules.

In Canada, awareness of LTC financial risks is low in part because policy debates are relatively silent on this issue compared to other OECD countries. Given the budgetary pressures from an expanded public LTC system, most other countries have opted for some type of public-private financing system that encourages greater private risk-pooling while ensuring that public subsidies go to those who need it the most, as discussed in Appendix B.

The Crowding-out Phenomenon

Lack of awareness that government doesn't cover most LTC expenses surely is one reason why private insurance protection for these costs remains relatively rare in Canada. But another equally plausible reason is that even though they are limited in some respects, existing provincial subsidy programs nevertheless remove one of the most important motives for private LTC insurance – necessity. Because all provincial programs respect the principle of guaranteeing LTC access for those who cannot pay, private insurance is not seen as necessary to be protected against the worst contingency: to be in urgent need of LTC and without enough funds to access it.

Moreover, in those provinces where the copayments that are required from institutionalized patients (or recipients of home care) depend on their ability to pay, the incentive for low-income patients

20 Options along these lines commonly include reverse mortgages, roll-up mortgages and other forms of equity release.

21 In a separate survey, roughly 60 percent of Canadians say that they are going to rely fully on the public system for their LTC needs (CMA 2013)

to get insurance protection is sharply reduced, since the amounts that they would have to pay for LTC if they did not have insurance would be lower than if they are covered.[22] For these patients there is little or no net income gain from being insured, since the government subsidy is reduced, typically dollar for dollar, by the benefits from a private insurance plan; with hindsight, they wasted the money they paid for being privately insured.

In systems where there are government programs that ensure access to needed LTC for those without the means to pay for it, the existence of an access guarantee effectively acts as an implicit public insurance plan that "crowds out" private LTC insurance to a significant extent. Because of the crowding-out phenomenon, private insurance of this type will tend to be bought mostly by individuals and families with high income and assets that they want to preserve and pass on to later generations.[23]

While crowding-out reduces the demand for private LTC insurance, however, it does not eliminate it. If provincial governments pursue policies that raise patients' share of LTC costs through measures such as higher maximum co-payments or by including assets in determining a patient's eligibility for subsidies, the expected LTC cost would rise for many seniors and their families. This, in turn, would increase the demand for LTC insurance among those with assets that they wanted to protect.

For example, if provinces were to introduce rules under which some LTC charges would be payable after the patient's death, private insurance could offer plans that would pay any such costs, thus protecting assets for his or her heirs. Alternatively, insurers could offer a form of life insurance coverage with benefits that would only be paid in full to the patient's estate if he or she had incurred a specified minimum amount of LTC charges before death. Plans of this type would make it possible for seniors to ensure that their heirs would receive at least a given predetermined inheritance, regardless of the LTC costs that they incurred before death.[24]

The Role for Greater Private Savings

The most important issue with respect to LTC financing over the next several decades relates to its impact on intergenerational equity, given the pressures that the retirement of babyboomers will place on younger taxpayers. However, the question of government's obligation to support the expenditure needs and general living standards of the elderly is a more general one and would be relevant even in the absence of the coming demographic imbalance. In particular, it revolves around the relationship between taxation, on the one hand, and incentives to work and save, on the other.

If government took on a large portion of the responsibility for financing the elderly's

22 Presumably, provincial authorities include any benefits from LTC insurance in patients' income or assets when determining a patient's ability to pay. In the US, this principle is sometimes described by saying that the insurance plan is the "first payer" of LTC costs.

23 The crowding-out phenomenon is probably the most widely accepted explanation for what used to be known in the literature as the "long-term care insurance puzzle" (Brown and Finkelstein, 2008). For their part, Grignon and Bernier go so far as to state that "programs of last resort" (that is, what we call an access guarantee) "cannot coexist with a private insurance market" (2012, p. 17). As explained in the text, we think this is an overstatement.

24 An implicit assumption is that benefits from such plans would not increase any amount collected by government from estates as deferred LTC charges due from the deceased person. In the US, a number of states explicitly exempt insurance benefits when calculating the value of a deceased's estate (Blomqvist and Busby 2012).

consumption and other expenditure needs, the incentives on working people to save for their retirement would be reduced. Programs that benefited the elderly more generously would have to be financed by raising more tax revenue, and most forms of taxation also reduce the incentives for people to work and save. Other things equal, these incentive effects will affect an economy's overall performance, reducing the rate of growth of output and living standards at least to some extent.

In that sense, therefore, society faces a trade-off: the benefits of more generous programs for the elderly must be weighed against the negative effects on the economy's overall performance. With respect to financing LTC, the demographic imbalance that Canada faces in the coming decades makes the trade-off more difficult than it would be otherwise, but it would be a relevant one even without it.

Increasing recipients' share of LTC costs by imposing stringent means-testing rules along the lines discussed above will increase working peoples' incentives to save for retirement, at least for those who want to protect assets for their heirs. Regulatory provisions that allow individuals to acquire insurance that indirectly protects such assets against being depleted by high LTC costs would also make it more attractive to save for the benefit of one's heirs.

In addition, both the federal government and the provinces have important tools to increase private savings for LTC and retirement consumption. These features include tax deferral in Registered Retirement Savings Plans and the tax exemption from earnings in Tax-Free Savings Accounts.

In the UK, where the income tax system includes similar tax deferral and exemption provisions, the British Bankers' Association – in a brief to a royal commission on LTC – suggested that taxation of the proceeds from retirement income funds could be further liberalized to provide added incentive for individuals to sign up for private LTC insurance. Specifically, it proposed that, while remaining tax-free, a lump-sum pension transfer could be taken upon retirement (up to 25 percent of the total pension) and be used for the purchase of LTC insurance.[25] Rules of this kind deserve consideration in Canada as well.

Private financing for LTC costs has much in common with pension savings. Both require that money be put aside when income is high and during an individual's working life. Both require advanced planning as the probability of one living long enough to retire is similar to the likelihood of living long enough to retire and need support with routine daily activities. At present, there are great concerns in Canada as to whether working-age individuals are saving enough for their retirement, even with the partial incentives that the tax system currently contains to encourage them to do so, and even though the tax system already compels Canadians to contribute specified amounts to the CPP.

Although the issue is controversial, proposals to address the problem of the perceived savings deficiency by increasing the contributions individuals are required to make to a retirement fund through the tax system (that is, effectively expanding the CPP) are favoured by many, including the current Ontario government. Even though requiring individuals to contribute larger amounts to a retirement fund does not necessarily mean that they will raise their net savings – if

25 This would avoid the mandatory transfer of funds in an RRSP into a Registered Retired Income Fund or RRIF at age 71, and act similar to a Registered Education Savings Plan or RESP for the elderly, except with taxable withdrawals allowable for LTC expenses beginning at age 75.

they want, they can offset their pension fund contributions by borrowing to finance additional consumption – the evidence from the literature on behavioural economics suggests that most take the former path, increasing their net savings.

One way to increase accumulation of assets to pay for LTC could therefore be the creation of an LTC social insurance plan from which retired people would draw as they needed it. In the language of behavioural economics, the "default option" under this plan would be to contribute a monthly amount for LTC insurance out of any earned income, along the same line as under the CPP. Even if individuals were allowed to opt out of the plan, many most likely would not, again because of the tendency for most people to stick with the default option when one is available. Again, we believe provinces should give consideration to establishing plans of this kind, but in a way that does not aggravate the problem of intergenerational equity.[26]

CONCLUSION

The apparently simple solution of expanding Canada's public health system to cover all LTC costs should be rejected due to the additional stress that the expected growth in costs – a near tripling over the next 40 years – would put on future budgets and taxpayers of working age. A multi-pronged solution to better target public means-tested subsidies and allow growth of private insurance and savings should be pursued instead.

Policymakers could do so in a manner that assures LTC access for those who need it, but can't afford it, while encouraging individuals to take on a greater responsibility to pay for their own future LTC. This approach would achieve a better balance between the costs to government – taxpayers – those that can be reasonably borne by individuals.

Striking such a balance requires serious consideration of intergenerational equity issues. In concrete terms, provincial governments should proactively pay attention to the growth in LTC costs as the "gray tsunami" begins to build and formulate a consistent set of means tests to determine what patients will have to pay and appropriate subsidies if and when they no longer have the means to do so.

Clear and widely publicized rules of this kind would go a long way to help boost personal savings for LTC and increase the demand for insurance from individuals who want to secure their assets for future generations.

Policymakers, meanwhile, face many urgent issues with respect to guaranteeing LTC access for those who cannot pay for it themselves. They include waiting lists and the need to change the balance between institutional and home-based care so as to better correspond to the preferences of LTC recipients and their families. Although we do not discuss policies to address these issues in this *Commentary*, we believe they should be another priority over the next several years.

On the financing side, even though we recognize the appeal of bringing the financing of LTC closer to the model used for physician and hospital services under the *Canada Health Act*, now is not the right time to do so.

26 For example, this might mean age-based contribution rates that increase as individuals approach retirement, or by making payouts closely linked to contributions. Such payouts would be in cash as opposed to in-kind benefits. See Robson and Busby (2011) for a lengthy discussion of what a CPP-style plan might look like.

Appendix A – A Framework for Calculating and Projecting Long-term Care Costs for Seniors

To estimate current, and project future, long-term care costs in Canada, we draw on publicly available information from several different sources. It's important to keep in mind, however, that because our projections depend on a variety of assumptions based on the status quo of LTC funding in Canada, they are, like all projections or forecasts, not iron clad. It is very possible that provincial governments in Canada are not able to keep pace with the way in which LTC has been financed in the past, and will alter their policy decisions to improve productivity or shift some of the costs onto private individuals. Nonetheless, we think it valuable to project what future LTC costs would be like were the status quo to continue, as it encourages a discussion around the options and need for specific policy responses.

We start by taking Statistics Canada's population projections for seniors – version M1, the medium growth assumptions. From here, our calculations break down current and future demand for long-term care services into three broad categories: care provided in institutions, at home by paid ("formal") caregivers, and by informal caregivers.[27] The first step is to determine the number of individuals in each category, which we later use to determine the per person care costs by location of care.

Care in Institutions

The first part of our analysis calculates the number of individuals receiving care in long-term care institutions. For this, we use Census results, which show the percentage of the population aged 65 and over living in special care facilities, by five-year age group (Table A1; Columns 1-3). We apply these rates to past and future population figures to calculate the number of individuals receiving care in institutions.[28]

Hospital-Based Long-Term Care

A portion of long-term care costs are borne by hospitals: many long-term care services are currently provided in long-term and chronic-care hospitals. Undesirably, many patients also receive long-term care in acute-care hospitals because there is no bed available in a nursing home or adequate care in the community. In the literature, these individuals are often referred to by the acronym ALC, for "Alternate Levels of Care." The Canadian Medical Association estimates that around 7,500 acute care beds in Canada are used for LTC purposes on any given day.

Formal and Informal Homecare

Homecare is usually provided to a much larger patient population than those in institutions. For example, an early estimate by CIHI states that

27 This is broadly similar to the methodology found in European Commission (2012), with a few unique exceptions.

28 According to one of its pamphlets, the data collected by CIHI on long-term care refers to institutions that are "approved, funded, or licensed" by provincial departments of health and social services, and include hospitals with long-term or chronic care beds as well as "residential care facilities with 24-hour nursing care (such as long-term care, nursing, or personal care homes)." According to Statistics Canada's 2011 Census, many elderly individuals also reside in what are variously referred to as "seniors' residences" or "supportive housing" in which services are available for some activities that a healthy and active person can carry out on his or her own. In the 2011 Census, some 128,000 seniors are recorded as living in "residences for senior citizens" (Statistics Canada 2012a) which are defined in the Census Dictionary as "collective dwellings that provide support services (such as meals, housekeeping, medication supervision, assistance in bathing) and supervision for elderly residents who are independent in most activities of daily living."

some 2.5 percent of Canada's population reported receiving homecare and home support at some time in 2006; another source gives a figure of more than a million persons, closer to 3 percent of the population, in 2009 (Statistics Canada 2012). Some 85 percent of homecare clients are older than 65, according to a sample for 2012-13 published by CIHI on its website, with an average client age of 78.[29]

Statistics Canada also publishes survey results that show, by 10-year age cohort, the percentage of individuals aged 65 and older receiving homecare at least once in the last 12 months (Table A-1; Columns 6-8). These figures can be used to derive a rough estimate of the number of individuals receiving long-term care services in home settings.[30] Regarding the total number of people receiving homecare, we can further break down these results into those who receive formal and informal care.

Based on Statistics Canada (2012), we know that roughly 16 percent of all homecare recipients get formal care only, over one-half get informal care only, while the remaining third is mixed.[31] We use these estimates, together with the age-specific rates in Table A1, for projecting the number of individuals who will receive these three different types of home in future years.

To make projections for the total costs – either in an institution, as formal care at home, or informal care – we first need estimates of the average costs of care per user in each setting. We do so by compiling information on the total costs of care in a given year, by location of care, and divide these results by our estimates for the number of individuals in each type of care.

The Cost of Institution-Based Care

Estimates of the extent and cost of LTC in institutions must be interpreted with caution, as they vary a great deal, depending on how LTC is defined. With respect to institutional care, ambiguity can arise both in differentiating LTC from various kinds of acute care provided in hospitals, and in defining where to draw the line between health-related costs and general living costs for persons who live in residences where they receive help with some of the activities of daily living.

In the OECD's Canadian statistics provided by CIHI, most LTC costs for institutionalized patients are shown under the expenditure category "other institutions," which includes the cost operating the nursing homes in which many LTC patients are housed.[32] The CIHI data in this category do not include the cost of facilities "solely of a custodial or domiciliary nature" (CIHI 2013, p 83), even though some of these may be "seniors' residences"

29 CIHI Home Care Reporting System (2014). However, there is variation in the frequency with which homecare is supplied to recipients. As an example, a Government of Ontario website states that in 2012-13, the Community Care Access Centers that arrange for homecare in Ontario did so for some 650,000 clients (www.homecareontario.ca, Facts and Figures), but the number of patients who received care under CCAC auspices on any given day was less than a third that number.

30 These are estimates, of course, and it may be that some individuals who receive homecare in the last 12 months also end up receiving care in a LTC institution as well, so there may be some double counting.

31 In fact, around 7 percent of seniors report receiving a mix of informal and formal care. For simplicity, for seniors who receive a mix of care, we assume that the allocation between informal and formal care is roughly split.

32 The CIHI data for "other institutions" includes nursing homes and other residential care facilities, as well as facilities for persons with physical and psychiatric disabilities, emotionally disturbed children, development delays, and alcohol and drug problems. The data provided to OECD (2013) from CIHI include only spending for nursing homes and other residential care facilities, as the other spending items were claimed to be a very small portion of all "other institution" spending.

Table A1: Assumptions for Location of Care

	Care in Institution				Care at Home		
	Male	Female	Total		Male	Female	Total
Age Group	*(percent of age group)*			Age Group	*(percent of age group)*		
65-69	0.9	1.0	0.9	65-74	11.7	18.2	15.1
70-74	1.7	2.3	2.0				
75-79	3.7	5.7	4.8	75-84	21.9	36.6	30.1
80-84	8.3	13.6	11.4				
85+	21.5	33.4	29.6	85+	44.1	59.4	54.0

Source: Columns 2-4: Statistics Canada 2012a, Table 4; in percent of the relevant population age group; data refer to 2011 Census. Columns 6-8: Statistics Canada 2012, in percent of the non-institutionalized population.

or retirement homes that offer various kinds of support for elderly residents who need help with some activities of daily living, and therefore cost more to live in than regular apartments.

The question whether patients in such residences should be classified as LTC patients, however, draws attention to a related issue: the fact that part of the cost of operating institutions such as seniors' residences and nursing homes corresponds to expenditures for room and board that the residents would have had to pay for if they were in good health. In the CIHI data on "other institutions," the total costs of institutions such as nursing homes are included, with no attempt to separate out the costs attributable to normal board and lodging. On that account, therefore, it can be argued that the conventional statistics in this category imply some degree of overestimation of the health-related costs of LTC.

Given the definitional ambiguities, it is perhaps not surprising that estimates of the aggregate cost of institutional LTC in Canada are scarce. In recent international comparisons of LTC costs undertaken by the OECD (2011), Canada is shown as spending the equivalent of 1.5 percent of GDP on both institutional and home-based LTC, close to the OECD country average. In the most recent CIHI statistics, the cost attributable to "other institutions" in 2013 is estimated as C$22.3 billion. With a current GDP figure around C$1.8 trillion, this again corresponds to a little over 1.2 percent of GDP.

Because not all long-term care spending data are recent, we use 2010 figures as the base year for our projections. CIHI calculates that LTC spending in "other institutions" was approximately $20.0 billion that year, roughly $56,000 per person aged 65 and up in institutionalized care ($20 billion divided by 356,000). We assume that the unit costs for

LTC in institutions therefore are roughly $56,000 per person annually in 2010, or about $60,200 in 2014 dollars. While this calculation is a crude approximation at best, it is of a similar order of magnitude as estimates in other studies.

Hospital-Based LTC

The number of people receiving long-term care in hospitals – either as ALC patients or in specific long-term care hospitals – would not be included in CIHI's estimates for "other institutions." Ontario-based estimates have pegged the monthly cost of delivering LTC in hospitals at roughly $25,000 per person (CHLIA 2012) – a much higher cost than the annual institutional cost of $56,000, which we solve for above. While long-term care services provided in hospitals are without doubt a major public cost, we assume that with appropriate reforms to better locate these patients, most ALC patients will, in the future, find appropriate care in nursing homes or other residential facilities. Therefore, we apply the per-patient costs for LTC in institutions to cover the number of ALC patients in Canadian hospitals.

The Cost of Formal Homecare

In the most widely quoted statistics on LTC, homecare is shown as a much smaller amount than the cost of institutional care. As for the case of institutional LTC, estimates of the aggregate cost of homecare must also be interpreted with caution. One source of ambiguity stems from the fact that formal homecare either comes in the form of services supplied by trained professionals such as nurses, physiotherapists, and social workers (sometimes referred to as "home health services"), or in the form of "home support services" supplied by "home support workers," variously referred to as home health aides, personal care workers, home health attendants, and so on. In the national health expenditure data collected by CIHI, where homecare is included in – and difficult to disaggregate from – "other" expenditure, the focus is on the former.[33] According to CIHI, this is in accordance with guidelines issued by OECD under which national statistical agencies are supposed to classify home support services under "social services" and not include them in estimates of aggregate healthcare costs. While the distinction between health and social services may be relevant for administrative purposes, both of them contribute to the burden associated with chronic illness and disability in old age.

In estimates of aggregate Canadian government LTC costs that were supplied by CIHI to OECD in 2006, homecare was said to account for roughly 20 percent of the total, or 0.3 percent of GDP. Applying this to the GDP of 2013 (about C$1,800 billion) would imply an amount of about C$5.5 billion.[34]

CIHI (2007) estimated total government homecare spending – inclusive of home health and home support services – at $3.4 billion in 2004, having grown at a rate of 9.2 percent, annually, over

33 We note that in recording the costs of homecare, most formal estimates ignore the private overhead costs for room and board, which are normally included in institutional LTC costs. The lack of a conclusive figure for homecare costs calls into question, to a certain degree, whether the conventional wisdom – that homecare is cheaper to provide than institutional-based care – is true, or if a larger share of homecare costs is simply borne by individuals and not recorded in many formal cost estimates.

34 While recent estimates that include both private and public spending on homecare are not available, data on public spending alone are available from provincial government accounts. As an example, the government of Ontario alone spent some C$2.1 billion on homecare in 2011.

the prior decade. Assuming that annual government spending on homecare grew at the same average rate as in the previous decade – a conservative estimate – total government spending on homecare would be approximately $5.8 billion in 2010, or about $10,000 per formal homecare recipient, or $10,800 in 2014 dollars. We use this as our estimate for public homecare spending per person.

But government only pays for part of formal homecare costs, both because there are substantial co-payments by patients in most provinces, and because a large share of homecare is purchased privately by patients, with no government subsidy. In some studies, it has been estimated that private expenditures on homecare are of the same order of magnitude as what the government pays (Canadian Healthcare Association 2009). To make a conservative estimate, we assume that private homecare costs are roughly two-thirds of the total public costs, suggesting that the total private and public cost could be as high as $9.6 billion in 2010, or $16,700 per formal homecare recipient (about $18,000 in 2014 dollars). This forms the basis of our estimates for private and total homecare spending per person.

Informal Care: The Hidden Contribution

In addition to the care that elderly sick and frail individuals receive in institutions or from paid health professionals and support workers in their homes, many of them also rely on help from family and friends. Since this "informal care" typically is supplied without an official transaction, it is not well captured in conventional statistics on the cost of LTC. However, from various surveys it is clear that informal care costs constitutes a large component of total long-term care costs.

Supplementary Informal Care: Many individuals who qualified for formal care also received a significant portion – in the range of 70 to 75 percent – of their total care by family members or friends (Health Council of Canada 2012). We assume that roughly 75 percent of all care provided to formal homecare recipients is supplementary informal homecare. And because the majority of informal care is provided by spouses, we calculate the costs for these services at a fraction – one half – of the wage rate that professional formal care providers charge. With these assumptions, the estimated cost of informal care provided to recipients of subsidized formal care is 1.5 times the total cost of formal care, or about $14.3 billion in 2010.

Informal Care Only: Assessing the economic value of unpaid informal caregiving is obviously difficult, for both conceptual and practical reasons, but it is clear that it is quite large (Keating et al. 2014). In a careful study based on the 2000 data that used detailed information on how many hours of different types of care had been given on average, and valued these hours at market wage rates for comparable work, Hollander et al. (2008) estimated the aggregate value of the informal care provided in 2002 at a minimum of $13 billion to a high of $31 billion. If a similar estimate could be made using the most recent estimates of the number of caregivers and current wage rates, the estimate would obviously be even higher, and would dwarf the estimated $5.8 billion that provincial governments currently spend on different kinds of paid homecare.

For simplicity, we assume a mid-range estimate based on Hollander et al. (2008), of around $22 billion in 2002, which we allow to grow with estimates of the dependent population. This estimate sees informal costs grows to around $27 billion in 2010. We subtract from this figure our earlier estimate of the costs of informal care received by subsidized formal homecare patients, about $14.3 billion, which leaves about $12.6 billion as a remainder. Divided among the number of those who receive only informal care at home, this amounts to around $20,400 per person in 2010 or $21,900 in 2014 dollars, which we use as the basis for our projections.

APPENDIX B

CLARIFYING THE PUBLIC SUBSIDY TO ENCOURAGE BETTER RISK-POOLING

Broadly speaking, the thrust of reforms to LTC financing in comparable Western countries have been to better clarify rules for the public subsidies as well as develop ways to better target public funds while encouraging the growth of private risk pooling and savings.

The design of other international LTC financing systems offers insight as to what Canadian policymakers should be considering when choosing better LTC policies. We look at three models with lessons for Canada: 1) France, which has the largest per capita rate of voluntary private LTC insurance among OECD countries, with public LTC subsidies offered as vouchers; 2) The UK, which has undertaken numerous public commissions on the issue of LTC financing and most recently proposed a back-ended public LTC plan; 3) The US, which has the largest private LTC insurance market in the world, uses tax deductions to encourage the purchase of insurance, yet is still looking for solutions to encourage greater private LTC savings among individuals.

France – Defined Public Coverage and Broad Private Risk Pooling

France is a unique example of a complementary long-term care financing structure that has resulted in a public-private split. Public debates seem to have raised the profile of the issue and of the financial risks surrounding LTC. There is a large private LTC insurance market in France with about 3 million policy holders in 2009. The public *Allocation Personalisee d'Autonomie* (APA), created in 2002, is designed for those aged 60+ who are no longer able to care for themselves. Public payments are graduated according to the recipient's income, are given in cash and can be used as the recipient sees fit. With a voucher system, the preferred location for individual care is shifting towards the home and away from institutions in France. Most adult children are legally compelled to financially assist parents who have exhausted their own resources, and those with low-incomes are exempt from paying APA copayments.

The French government measures dependency using a scale of 15 items that make up daily living dependency needs. The scale is used to determine the public LTC benefits, and some private insurers piggy-back on this scale to determine eligibility for supplementary insurance benefits. Much private LTC insurance is offered through group products, and there are no tax incentives to encourage the development of LTC insurance. That said, a dependent person can benefit from a tax deduction if he or she hires a caregiver, and taxable income would be reduced if a dependent parent resides with his or her child.

Lessons for Canada: The French LTC financing model offers a clear framework for public LTC costs by defining the public subsidy according to one's needs and income. This guarantees access on one hand, and on the other hand, private insurance has grown as a supplement to the public cash benefits, often using the public disability screen to determine eligibility for claimants. This model also shows how important it is for individuals to understand the size of public subsidies to better plan privately for them, and that a private insurance market can grow without tax incentives. On the downside, the major issue with a voucher system is whether it would require new public money to come into the system if it would subsidize already existing private funding for long-term care.

UK – Clarity on Private Responsibilities with Public Catastrophic Coverage

In the United Kingdom, there has been an extraordinary level of debate about how to finance long-term care over the last decade – with over three public commissions on the subject during this time – and little agreement on how best to proceed.

The most recent policy proposal emphasizes the development of a public-private LTC financing model with back-ended public coverage for the financial risks associated with LTC.

The United Kingdom will introduce a funding system that sets a lifetime cap on the amount individuals would have to pay for long-term care services. For example, once adjusting for assets and income, individuals would be responsible to pay for (up to) the first $120,000 (about £72,000) of costs for eligible long-term care services after which, for the rest of their life, long-term care costs would be covered by the state. Access to care is guaranteed: those without enough means to afford this amount would still qualify for public support.

Much like in Canada, there has historically been ambiguity in the UK about whether governments will cover an individual's future LTC costs. Under the current proposal, government funds would be both targeted to those who are less able to pay, and provide support to those who incur catastrophic costs for long-term care. Further, the reforms make clear the public-versus-private cost share. By reducing this ambiguity, individuals — and the public at large — would have strong incentives to prepare for future costs. On the downside, the protection against catastrophic costs would benefit mainly the well-off, and ensure a form of inheritance protection by the state.

Lessons for Canada: Most of the UK public commissions that studied LTC financing determined that it would place too much pressure on public finances were governments to take on all LTC costs. Further, much like in Canada, citizens were confused about the size of the government LTC subsidy, which has stunted the growth of any private risk-pooling market. To develop a public-private financing solution, and ensure greater private savings and risk-pooling, the most recent proposal to cover the back-end catastrophic costs of LTC would still ensure that those without private resources would have access to care and at the same time would likely create a market for private risk-pooling.

US – Demand Side Encouragement of LTC Insurance, Lack of Private Savings for LTC

Much like in the UK, the US guarantees access to long-term care by offering last-resort public coverage for LTC risks, but without specifying a maximum amount of private expenditure. It is an extreme example as it requires near full depletion of assets to qualify for LTC subsidies. The LTC subsidies are not paid for through the US's Medicare program, the federal social insurance program for individuals aged 65 and up. Instead, one can only qualify for LTC benefits through the state Medicaid plans, which is the social health insurance program for individuals with low income.

There is great concern among US policymakers about the lack of savings and planning for future LTC risks. To encourage greater risk-pooling for future LTC risks, the US has opted for demand-side approaches, such as tax deductions for the purchase of private LTC insurance. There are nearly 5 million Americans with LTC insurance, and the LTC insurance market in the US is one of the largest worldwide, perhaps partly because the restrictive rules under which individuals are eligible for Medicaid LTC subsidies are well known.

The federal government, as well as some state governments, has also attempted to alleviate concerns over the affordability and attractiveness of LTC insurance in the hope that this will boost private LTC insurance purchases and shift more of the LTC cost burden onto individuals. There is an assortment of tax-based incentives to encourage private LTC insurance purchases, found mainly in the Health Insurance Portability and Accountability Act (HIPAA), but as a share of the population LTC coverage is still small (American Academy of Actuaries 2001). Projections suggest that the incentives will increase the purchase of private insurance, particularly the incentives that target individuals still in the labour force (Wiener et al. 1994). That said, research into the net savings to the public sector suggest that they are uncertain– projections range from Medicaid savings of

anywhere from 25 to 81 cents per dollar of revenue lost to the incentives (American Academy of Actuaries 2001). The downside of these policies is the concern that the majority of individuals claiming the tax deductions are those who would have taken our private insurance anyway, so the incentives essentially use public funds to help finance the LTC of the well off.

Saving for long-term care needs requires financial planning well in advance. And overcoming the natural myopic tendencies of individuals to ignore future risks has dominated the thinking of policymakers in recent years, manifesting itself with the Community Living Assistance and Services Act, (CLASS) proposal in the earlier drafts of the *Affordable Care Act* reforms in the US.

In broad strokes, the proposal was a form of government-managed voluntary insurance. It would offer benefit coverage in the form of cash to individuals, with enrollment available to all regardless of illness history and offered as part of employer benefit packages. Cash benefits could be used for any type of LTC need, and as a voluntary plan, it allowed individuals to opt out. However, due to concerns over enrollment, financial viability, and objections that many low-income individuals' contributions to this plan would directly reduce their Medicaid benefits, the plan was withdrawn.

Lessons for Canada: Access to public LTC subsidies in the US is only available for the destitute, and those who have depleted nearly all of their assets and income, and the US has recognized the need to encourage private risk-pooling of LTC costs. It has done so both with clear rules around the public subsidy and with tax incentives for individuals to take up private LTC insurance.

The idea behind the CLASS proposal might resonate with Canadian policymakers looking to boost private savings via some type of government-managed social insurance plan. Even if it were voluntary in the sense that individuals would be allowed to opt out of the plan, it might end with a large enrollment if properly promoted, lowering the administrative costs, and forcing individuals to consider the need to save and get insurance for LTC costs well before retirement. Busby and Robson (2011) discuss how a similar type of plan might work to fund old-age drug benefits in Ontario. Generally speaking, by linking benefits to contributions much of the intergenerational concern could be resolved, and concerns about interprovincial migration and eligibility can be overcome with cash-based benefits.

REFERENCES

American Academy of Actuaries. 2001. "Federal Tax Incentives for Long-term Care Insurance: Actuarial Issues and Policy Implications." Issue Brief: American Academy of Actuaries.

Blomqvist, Ake, and Colin Busby. 2012. "Long-Term Care for the Elderly: Challenges and Policy Options." Commentary no. 367. Toronto: C.D. Howe Institute. November.

Canadian Medical Association (CMA). 2013a. "13th Annual National Report Card on Health Care." An Ipsos-Reid Public Affairs Survey. Ottawa: CMA. August.

CMA. 2013b. "CMA Submission: The Need for Health Infrastructure in Canada." Submission to Minister of Transport. March.

Canadian Healthcare Association. 2009. "Homecare in Canada: From the Margins to the Mainstream." Canadian Healthcare Association: Ottawa.

Canadian Health and Life Insurance Association Inc. (CHLIA). 2012. "Improving the Accessibility, Quality and Sustainability of Long-term Care in Canada." Canadian Health and Life Insurance Association Inc.: Toronto. June.

CHLIA. 2013. "Canadian Seniors Ill Prepared For Long-term Care Needs." Leger Marketing Survey. https://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/page/9E3C3F4F200DB65985257B56006B93A4 (Date of Access: May 25, 2014)

Canadian Institute for Health Information (CIHI). 2007. "Public-Sector Expenditures and Utilization of Homecare Services in Canada: Exploring the Data." CIHI Report using NHEX database. Ottawa: CIHI. March.

CIHI. 2013. "National Health Expenditure Trends." Ottawa: Canadian Institute for Health Information.

——. 2014. "Home Care Reporting System. Quickstats: Selected Characteristics of Home Care Clients 2012-13."

Congressional Budget Office (CBO). 2013. "Rising Demand for Long-term Services and Supports for Elderly People." Congress of the United States Congressional Budget Office. Washington, DC. June.

Costa-Font, Joan, and Christophe Courbage. 2011. *Financing Long-term Care in Europe: Institutions, Markets and Models.* Joan Costa-Font and Christophe Courbage, eds. Palgrave Macmillan.

European Commission. 2012. "The 2012 Ageing Report: Economic and Budgetary Projections for the 27 EU Member States." European Economy Report. Brussels: European Commission.

Health Council of Canada. 2012. "Seniors in Need; Caregivers in Distress: What are the Home Care Priorities for Seniors in Canada?" Health Council of Canada: Ottawa. April.

Hollander, Marcus, Neena Chappell, Betty Havens, Carol McWilliam, and Jo Ann Miller. 2002. "Study of the Costs and Outcomes of Homecare and Residential Long-term Care Services." A Report prepared for the Health Transition Fund, Health Canada. http://www.homecarestudy.com/reports/full-text/substudy-05-final_report.pdf (Date of Access: June 5, 2014)

Hollander, Marcus, Guiping Liu and Neena Chappell. 2008. "Unpaid Caregivers in Canada: Replacement Cost Estimates." Final Report to the Policy Research Directorate, Human Resources and Social Development Canada. HRSDC: Ottawa. December.

Hurley, Jeremiah. 2010. *Health Economics.* Toronto: McGraw-Hill-Ryerson.

Keating, Norah C., Janet Fast, Donna Lero, Sarah Lucas, Jacquie Eales. 2014. "A Taxonomy of the Economic Costs of Family Care to Adults." *Journal of the Economics of Ageing.* March.

Kotlikoff, Laurence J. and Scott Burns. 2012. The Clash of Generations: *Saving Ourselves, Our Kids, and Our Economy.* The MIT Press.

Osberg, Lars. 2001. "Poverty Among Senior Citizens: A Canadian Success Story." *The State of Economics in Canada: Festschrift in Honour of David Slater.* Patrick Grady and Andrew Sharpe eds.. Kingston: Queen's University.

Organisation for Economic Cooperation and Development (OECD). 2013. "Public Spending on Health and Long-term Care: A New Set of Projections." OECD: Paris. June.

———. 2011. "Help Wanted: Providing and Paying for Long-term Care." OECD: Paris

Parliamentary Budget Office (PBO). 2012. "Federal Fiscal Sustainability and Elderly Benefits." Parliamentary Budget Office: Ottawa. February.

Robson, William B.P., and Colin Busby. 2011. *A Social Insurance Model for Pharmacare: Ontario's Options for a More Sustainable, Cost-Effective Drug Program.* Commentary 326. Toronto: C.D. Howe Institute. April.

Statistics Canada. 2012. "Seniors' Use of and Unmet Needs for Home Care, 2009." Melanie Hoover and Michelle Rotermann. Ottawa: Statistics Canada. December.

———. 2012a. "Census in Brief: Living Arrangements for Seniors." 98-312-X2011003.

United States Department of Labor. 2000. "Final Report of the Working Group on Long-term Care."

Walker, David. 2011. "Caring for our aging population and addressing alternate level of care." Report Submitted to the Minister of Health and Long-Term Care. Toronto. June.

Wiener, Joshua M., Laurel Hixon Illston and Raymond J. Hanley. 1994. *Sharing the Burden. Strategies for Public and Private Long-term Care Insurance.* The Brookings Institution: Washington, DC.

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